

**Treatment Access Expansion Project Executive Director Robert Greenwald  
Comments to Positive Women's Network  
May 4, 2010**

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I want to start my comments by saying that health care reform is a significant step forward in meeting the care and treatment needs of hundreds of thousands of people living with HIV and AIDS and millions of other Americans.

As we all know, the status quo is unacceptable, as many living with HIV and AIDS are uninsured and struggle to gain access to life-saving care and treatment.

Many get sick and some die because they cannot get the care they need to stay healthy.

To name a few, here are several of the key reforms that will make a significant difference in the lives of people living with HIV and AIDS:

**MEDICAID EXPANSION:** Through reform, starting in 2014, low-income people living with HIV and AIDS will finally have early access to Medicaid.

Many people believe that Medicaid was already a health care program for low-income uninsured people prior to reform.

This is not true, as in most cases in the context of HIV disease, you had to be low-income, uninsured and disabled to be eligible for Medicaid.

Until health care reform, there was no early access to care through Medicaid, despite the fact that the United States' own treatment guidelines for HIV call for early treatment interventions.

Health care reform puts an end—*starting in 2014*—to the cruel Medicaid policy that requires low-income, uninsured people living with HIV to become disabled by AIDS before they gain access to the Medicaid-based care and treatment that could keep them healthy.

As to women, in particular, more women than men are currently either uninsured or underinsured: 45% of women compared to 39% of men.

Approximately 4.5 million low income women who are currently uninsured will be eligible for Medicaid and have access to comprehensive benefits starting in 2014.

**MEDICARE PART D REFORM:** Through reform, the Medicare Part D donut hole is immediately reduced and gradually eliminated. And, starting in 2011, ADAP contributions will count toward Medicare beneficiaries' true-out-of-pocket spending requirements.

This is another significant step forward. It will greatly reduce the number of people living with HIV and AIDS on Medicare who lose access to their medications because they can't meet their co-payment obligations.

**PRIVATE HEALTH INSURANCE REFORM:** Through reform, private health insurance is more accessible and affordable for many people living with HIV and AIDS.

No longer may people living with HIV and AIDS be denied access to private health insurance based on their health condition, or charged higher premiums based on their health status or gender, or told they have a pre-existing condition. Only “reasonable” or coverage limits will be permitted.

What this means for women:

- No longer can women be charged more for insurance than men—or be charged more based on HIV or other health status. Prior to health care reform, on individual policies, women are charged 84% more than men for the same coverage.
- Insurers cannot deny coverage because of pre-existing conditions—such as a previous Cesarean section. In the past, insurers could refuse to pay for future C sections (now, one in every 3 births) or reject the application for insurance all together. There is also some evidence that insurers in the past rejected coverage for victims/survivors of domestic violence.
- Increasingly, women cannot be told that they have reached their coverage limit for reproductive health services, prenatal care, etc. In the past, many individual plans did not cover maternity care. And, even when covered, the costs were not regulated.

Through reform, there will be subsidies for those with low income to purchase health plans through the exchange, making private health insurance more affordable. And there are guarantees of access to a new mandatory benefits package.

The benefits package will include mandatory prescription drug coverage, mental health and substance use treatment, preventive and wellness services, and chronic disease management.

Through reform, more people living with HIV and AIDS will be able to purchase affordable private health insurance.

Health care-related bankruptcies and poverty will be greatly reduced.

What this means for women:

- Families with income up to 400% FPL (approx. \$88,000) will be eligible for subsidies to help them pay insurance premiums.
- Both private and public plans must now cover the full cost (no co-pays) of providing preventive services such as screening services (pap smears and mammographies) and immunizations.

A few additional improvements in women and their children's ability to access quality and affordable care:

- Parents will be able to keep their children under their insurance plans until the age of 26.
- Employers will be required to provide a reasonable break time for nursing mothers, along with appropriate space for those mothers to pump breast milk.
- The new law provides tax credits for small business owners who want to provide insurance coverage for their employees; most small businesses are owned and operated by women.

Health reform is a major step forward. But it is not the end of the story.

We secured a key victory, but to ensure true success there is more that Congress and the Obama Administration must do. (Of course, with our support and encouragement.)

I have four primary advocacy items to keep us moving forward and in the right direction. (I am not covering the anti-abortion provisions as part of my list because it is going to be covered by other speakers.)

**FIRST:** We need Congress to stay actively engaged in ensuring that we take no steps backwards and that health care reform is implemented in ways that maximize its promise. The devil is in the detail.

- a. Some of the billions of dollars in new investments in prevention, wellness, health disparities and workforce development, for example, must be targeted toward people living with HIV and AIDS.
- b. And, consumer representation from the HIV community must be secured on the many new task forces created in health care reform.

**SECOND:** We need a bridge to 2014 when the Medicaid expansion kicks in.

Low-income uninsured people, including the growing number of people on ADAP waiting lists, cannot wait until 2014 for care and treatment.

Without access to care now, too many peoples' health will be compromised and too many people will die. This is unacceptable.

- a. Congress must enact the Early Treatment for HIV Act now. (ETHA -- HR 1616; SB 833)

ETHA will give states the option to extend Medicaid coverage now through 2014 to pre-disabled, low-income people living with HIV.

- b. Congress must also appropriate emergency ADAP funding.

In recent months, eleven states have closed their doors to new clients. 13 states are on the brink of taking similar measures.

It is unacceptable to have waiting lists for life-saving medications, but the lists are growing daily.

**THIRD:** Congress must enact additional reforms to Medicaid—reforms that should have been, but were not, a part of health care reform.

- a. The benefits one receives through Medicaid should be the same as those now guaranteed through private, exchange-based insurance plans.

Under current Medicaid rules, each state establishes its own Medicaid benefits package. Even prescription drugs are an optional benefit.

As with the newly created private insurance exchange plans, we need a new mandatory minimum benefits package for Medicaid that ensures equal access to comprehensive benefits regardless of where one lives.

It is unfair that individuals in some states get better health care coverage through Medicaid than those living in poorer states.

This is in large part what drives health disparities and leaves many in poorer, southern states without access to quality health care.

Everyone in this country deserves equal access to quality health care. A necessary step is to create a new national Medicaid benefits package that is equal to the one created for private insurance plans through health care reform.

- b. Congress should mandate a permanent increase in Medicaid provider reimbursement rates for primary care providers and specialists.

Currently, Medicaid payment rates to providers are so low that health care institutions that serve large numbers of Medicaid patients are closing their doors across the country.

The health care reform bill contains some Medicaid reimbursement rate increases, but they are limited to primary care providers and only in effect in 2013-14.

Medicaid providers—including specialists like infectious disease doctors—need to be adequately reimbursed if care and treatment is to truly be available to Medicaid beneficiaries.

- c. And finally, as to Medicaid reforms, Congress must pass laws that reflect a sound approach to Medicaid access for immigrant populations.

Under current law, legal immigrants are generally barred from Medicaid during their first five years in the United States.

In Senator Max Baucus's original health care reform white paper, he proposed lifting this Medicaid ban, as doing so is cost-effective and good for both individual and public health outcomes.

It did not happen as part of health care reform, but must be enacted now.

**FOURTH:** Full support of the Ryan White Program is as important today as it was before health care reform was enacted.

Even when health care reform is fully implemented, significant gaps in care, treatment and essential support services will remain.

Gaps such as vision and dental care, which should have been addressed in reform, will continue to exist.

Gaps in access to transportation, housing, nutritional services, case management and treatment adherence, to name a few, will continue to exist.

The Ryan White Program was enacted to fill such gaps, and now is the time to fully fund the Ryan White Program and allow it to fulfill its mission.

In conclusion, we can not rest on this important victory.